questions that presented a pair of virtual patients who were prescribed different treatments defined by: reduction in the risks of nonfatal MI and fatal MI, treatment-related risk of serious infection, mode and frequency of administration, and monthly medication cost. Half of the choice questions asked respondents to select the treatment to which they would most likely be nonadherent. The other half asked respondents to state which of two virtual patients was better off after learning how adherent each was to each medication. Limited dependent-variable models were used to estimate weights indicating the impact of treatment and respondent characteristics on stated-adherence and quantifying the stated impact of nonadherence on respondents' well-being. **RESULTS:** Results indicated that reductions in the risk of a nonfatal MI had the largest effect on stated adherence, followed by medication cost, the risk of serious infection, and lastly mode and frequency of administration. Results also show that reductions in compliance had a significant impact on the perceived overall benefits of prophylactic treatments. **CONCLUSIONS:** We find that both clinical and nonclinical factors can impact treatment adherence, suggesting that the flexibility to include a variety of factors with SP models can be useful in understanding patient compliance.

PCV117

PATIENT ADHERENCE AMONG ADOLESCENTS WITH ARTERIAL HYPERTENSION

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OBJECTIVES: The aim of the study was to assessment of compliance by adolescents in the field of pharmacological and non-pharmacological methods of hypertension treatment. **METHODS:** The study included 62 patients (20 women, 42 men) diagnosed with hypertension and treated in specialist health care facilities. As a research tool was used questionnaire prepared on the basis of recent literature. **RESULTS:** The vast majority of respondents (72,7%) declared that regularly taking antihypertensive drugs. The proportion of patients regularly taking antihypertensive drugs was higher in patients treated with monotherapy than polytherapy (48,5% vs 24,2%). Among the methods of non-pharmacological treatment of hypertension the most accepted lifestyle change in the study population was smoking cessation (83,8% of respondents) and reduction of salt consumption (64,5% of respondents), and the least acceptable lifestyle change was to maintain proper body weight by eating a low calorie diet (30,6% of respondents). **CONCLUSIONS:** Adolescents with hypertension in varying degrees adhere to a medical recommendations related to the hypertension treatment. From the available literature data indicate that the current effective way to improve cooperation with the patient's is education.

PCV118

HEALTH STATE UTILITIES IN CHRONIC HEART FAILURE IN THE UK

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OBJECTIVES: Previous research has shown the impact of chronic heart failure (CHF) on health-related quality of life (HRQL). Less is known regarding the impact of reduced ejection fraction (HFrEF) on HRQL. The aim of this study was to elicit utility values for CHF with HFrEF or preserved ejection fraction (HFpEF) by New York Heart Association (NYHA) classification system in the UK. In addition, utility values for events such as stroke, myocardial infarction (MI) and chronic kidney disease (CKD) were estimated. **METHODS:** Health states were developed from concept elicitation interviews with CHF patients (N=10) and cardiologists (N=5). Draft health states were validated in cognitive debrief interviews with different patients (N=5) and cardiologists (N=4) and finalised with scientific input from experts. The resulting health states (n = 10) were piloted with general public to check understanding. General public participants (n=100) completed background questions and rated each state using visual analogue scale and time trade-off (TTO) assessments (with lead time method for states worse than dead). **RESULTS:** The mean TTO utility for HF-rEF ranged between 0.86 (SD=0.19) (NYHA class II); 0.60 (SD=0.23) (NYHA III) to 0.28 (SD=0.41) (NYHA IV). Equivalent values for HF-pEF were 0.83 (SD=0.24) (NYHA II); 0.55 (SD=0.28) (NYHA III) to 0.27 (SD=0.35) (class IV) respectively. Other values were post hospitalisation after stroke (mean=0.30, SD=0.43); post MI (mean=0.45, SD=0.37) and CKD (mean=0.78, SD=0.21). Post-hospitalisation states captured a period of upto three months after the event. **CONCLUSIONS:** This study shows the effect that NYHA class has on HRQL for people with CHF in the UK. The findings showed that HFrEF and HFpEF were very similar. Participants considered events such as recovery from stroke to have significant impact on HRQL. These are important data to consider in evaluating outcomes of treatments and should be reflected in cost effectiveness models in CHF where relevant.

PCV119

ACUTE AND CHRONIC IMPACT OF CARDIOVASCULAR EVENTS ON HEALTH STATE UTILITIES

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OBJECTIVES: Cost-utility models are frequently conducted to compare treatments intended to prevent or delay cardiovascular events. Most published utilities represent post-event health states without incorporating the disutility of the event or reporting the time between the event and utility assessment. Therefore, the objective of this study was to estimate health state utilities representing cardiovascular conditions while distinguishing between acute impact including the cardiovascular event and the chronic post-event impact. **METHODS:** Health states were drafted and refined based on literature review, clinician interviews, and a pilot study. Three cardiovascular conditions were described: stroke, acute coronary syndrome (ACS), and heart failure. One-year acute health states represented the event and gradual recovery; post-event health states represented chronic impact. UK general population respondents valued the health states in time trade-off tasks with time horizons of one year for acute states and ten years for chronic states. **RESULTS:** A total of 200 participants completed interviews (55% female; mean age = 46.6y). Among acute health states, stroke had the lowest utility (0.33), followed by heart failure (0.60) and ACS (0.67). Utility scores for chronic health states followed the same pattern: stroke (0.52), heart failure (0.57), and ACS (0.82). For stroke and ACS, acute utilities were significantly lower than utilities for chronic post-event (difference = 0.20 and 0.15, respectively; both $p < 0.0001$). **CONCLUSIONS:** Results add to previously published utilities for cardiovascular events by distinguishing between chronic post-event health states and acute health states that include the event and its immediate impact. Findings suggest that acute and chronic impact should be considered when selecting scores for use in cost-utility models. Thus, the current utilities provide a unique option that may be used to represent the acute and chronic impact of cardiovascular conditions in economic models comparing treatments that may delay or prevent the onset of cardiovascular events.

PCV120

HEALTH STATE IN PATIENTS WITH ATRIAL FIBRILLATION ON NEW ORAL ANTICOAGULANTS AS ASSESSED WITH THE NEW EQ-5D-5L QUESTIONNAIRE AT BASELINE AND 12-MONTH FOLLOW-UP: PREFER IN AF REGISTRY

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OBJECTIVES: We aimed to understand the short-term impact on quality of life associated with Non VKA Oral AntiCoagulants (NOACs) use in patients with AF. We obtained baseline (BL) and follow-up (FU) data on the health state of AF patients under everyday practice conditions in the PREvention oF thromboembolic events – European Registry in Atrial Fibrillation (PREFER in AF). **METHODS:** PREFER in AF documents AF patients in terms of clinical characteristics, management, quality of life and other outcome parameters. The EuroQol EQ-5D-5L descriptive system and visual analogue scale (VAS) were applied in PREFER in AF at BL and FU to obtain patient-reported generic health-related quality of life information and utility weights. **RESULTS:** Of the 6390 AF patients at follow-up 1895 (29.7%) had paroxysmal, 1533 (24.0%) persistent, 474 (7.4%) long-standing persistent, and 2488 (38.9%) permanent AF. Comorbidities were highly prevalent. 3344 AF patients (61.1% males, mean age 71.7 ± 9.85 years) provided EQ-5D-5L data both at BL and 12-month FU. On the VAS (range 0-100), the mean score at FU was 68.8 ±18.1 points, with no major differences between patients on NOACs (68.3), VKAs (68.9), AP (70.1), or VKA+AP (71.7), respectively. All scores improved from baseline from 0.36 in patients on VKA to 1.77 for those on AP. The overall utility index at FU was 0.80 ±0.21. At FU the 409 patients on NOACs had a utility score of 0.79 (change from BL, -0.01), the 1789 patients VKAs 0.80 (-0.01), the 237 patients on AP 0.81 (+0.01), the 151 patients on VKA and AP 0.80 (-0.01) and the 749 patients receiving neither VKAs nor AP 0.80 (0.00). **CONCLUSIONS:** Patients with AF present with reduced self-reported quality of life compared to the general population. Patients receiving NOACs had similar quality of life both at baseline and after 12-month FU, when compared to alternative medications.

PCV121

HEALTH STATE IN PATIENTS WITH VENOUS THROMBOEMBOLISM ON CONVENTIONAL AND NON-VKA ORAL ANTICOAGULANTS AS ASSESSED WITH THE EQ-5D-5L QUESTIONNAIRE: PREFER IN VTE REGISTRY

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OBJECTIVES: Non-VKA oral anticoagulants (NOAC), which do not need routine monitoring, have the potential to improve the quality of life (QoL) in patients on long-term treatment for venous thromboembolism (VTE). We aimed to obtain contemporary data on the health state of patients with VTE under daily practice conditions. **METHODS:** PREFER in VTE is a non-interventional study in 7 countries (France, Germany, Austria, Switzerland, Italy, Spain, UK) that prospectively documents patients after an event of acute deep venous thrombosis (DVT) or pulmonary embolism (PE) in terms of clinical characteristics, management, quality of life and other outcome parameters. The EuroQol EQ-5D-5L consists of the 5-dimension descriptive system used to derive utility scores and the visual analogue scale (VAS), measuring self-rated health (scale 0-100). **RESULTS:** A total of 2790 patients with acute VTE at baseline (BL: 1640 DVT, 1150 PE ±DVT) and 723 patients at an interim analysis at 6 months (443 DVT and 280 PE ±DVT) completed the EQ-5D-5L. On the EQ VAS for current health state, the mean score at 6 months was 73.8 points (change from BL +10.9), with similar values in DVT patients (74.6, change from BL +9.8) compared to PE patients (72.4, change from BL +12.4). Between BL and 6-month follow-up, index values increased in all medication classes (heparin only: 0.66 to 0.75; heparin/VKA: 0.70 to 0.84; NOAC: 0.73 to 0.87). Overall the index value increased from 0.69 to 0.83 (DVT: 0.71 to 0.85, PE: 0.67 to 0.81). **CONCLUSIONS:** Under clinical practice conditions, patients on NOAC and heparin/VKA had larger increases in their health state scores than those on heparin only. This generic QoL tool detected only small differences between treatment options. Six months after the event, patients with DVT had similar self-reported QoL on the VAS compared to patients with PE, and patients with DVT had somewhat higher utility values.